PHYSICIAN CERTIFICATION FOR LONG-TERM CARE SERVICES

State Form 38143 (R5 / 6-93) Form 450B / PASARR2A

Indiana Family and Social Services Administration (IFSSA)

CONFIDENTIAL

ASSESSMENT TYPE	MEDICAID STATUS
☐ Initial Assessment	☐ Medicaid Pending
☐ Re-Screening	☐ Medicaid Recipient
☐ ARR	☐ Non-Medicaid

Name of contact	Upon completion return to: ☐ Area PAS agency ☐ IFSSA ☐ Integrated Field Services Case Manager ☐ Other _____

I - RECIPIENT IDENTIFICATION

Name of applicant *(last, first, middle)*	Date of birth *(mo., day, yr.)*	Sex	Name of county
Name of nursing facility or ICF / MR	**Facility admission date *(mo., day, yr.)***		**Medicaid number**
Address of facility *(street and number)*	**Re-admission date from hospital**		**Level of care transfer date**
City, state and ZIP code	**Requested length of care** ☐ Short-term ☐ Long-term		**Facility provider number(s)** **"I".** **"S".**

Admitted from:

☐ a. Acute Hospital ☐ b. Psychiatric Bed ☐ c.Home ☐ d. Nursing Facility _____ ☐ e. ICF/MR ☐ f. Out-of-state _____ ☐ g. Other _____

II - PHYSICIAN'S MEDICAL EVALUATION

Federal and state regulations require a physician's medical evaluation, plan of treatment and explicit recommendation for care prior to admission or continued care in a nursing facility, the C.H.O.I.C.E. program, or the Medicaid Home and Community-Based Waiver program.

Patient Evaluation *(check all applicable boxes below. "*" requires explanation in "Clinical Summary")*

☐ Ambulatory	☐ Contractures	☐ Colostomy / Ileostomy	☐ Self Fed
☐ Wheelchair	☐ Incontinent *(bladder)*	☐ Other Ostomy	☐ I.V. Fluids / Nutrition *
☐ Cane or Walker	☐ Incontinent *(bowel)*	☐ Aphasic	☐ Tube Fed - Type _____
☐ Bedfast	☐ Catheter _____	☐ Agitated / Combative	☐ Decubiti *(size, stage, treatment)* *
☐ Ventilator Dependent	☐ Tracheotomy	☐ Confused / Disoriented	☐ Other *_____

Primary diagnosis *(include dates)*	Secondary / tertiary diagnosis *(include dates)*

Patient's overall prognosis

Plan and Treatment *(check all applicable boxes below. "*" requires explanation in "Clinical Summary")*

☐ Medications *(describe below)*	☐ Regular Diet	☐ Minimum Nursing Intervention	☐ Independent with ADLs
☐ *Restorative Services* *	☐ Other (specify _____	☐ Moderate Nursing Intervention *	☐ Assisted with ADLs
☐ *Sterile Dressing* *	☐ _____	☐ Intensive Nursing Intervention *	☐ Dependent for all ADLs

Medications *(dosage and frequency)*

Clinical summary *(attach additional information as necessary)*

LEVEL OF CARE PHYSICIAN CERTIFICATION

Complete for all Applications		**Complete for Home Care** *(if applicable)*
Level of care recommended	☐ Skilled ☐ Intermediate	☐ Medicaid Home and Community Based Waiver service
☐ ICF/MR - Large/Small	☐ Other *(specify)* _____	☐ C.H.O.I.C.E.

I certify that community supported in-home care is ☐ safe and feasible ☐ not safe or feasible in regard to health and safety of this patient. If not safe or feasible, explain.

Signature of physician *(stamps are NOT acceptable)*	Date signed *(month, day, year)*	Typed or printed name of physician

III - STATE DEPARTMENT AUTHORIZATION

This certification is for:

☐ Admission ☐ Transfer ☐ Continued Care

☐ Approved ☐ Disapproved

Effective Medicaid reimbursement date

Comments

Authorized signature ☐ IFSSA ☐ Area PAS agency

Date signed *(month, day, year)*

INSTRUCTIONS

Physician's Certification for Long-Term Care Services

1. Form 450B is used for both Medicaid and private-pay applicants for long-term care services and C.H.O.I.C.E. eligibility. Do not use for non-Medicaid/private pay individuals being readmitted from hospitalizations or being transferred to another facility.

2. Form 450B shall be completed for persons making application for long-term care services.

3. The recipient's or patient's physician shall complete Section II, PHYSICIAN'S MEDICAL EVALUATION, including the patient's evaluation, plan of treatment, specify a level of care, sign, date and return the original to the appropriate agency as designated below.

Pre-Admission Screening	Local PAS Agency
C.H.O.I.C.E.	Local Area Agency on Aging
ICF / MR	Integrated Field Services Case Manager
Facility Transfers	State Office of Medicaid Policy and Planning
Medicaid Waiver Application	Local Area Agency on Aging
Medicaid Waiver Redetermination	Waiver Case Manager

4. Form 450B will be sent to the State Office of Medicaid Policy and Planning for final review and determination.

   For C.H.O.I.C.E. applicants / clients and private pay applicants for long-term care, Form 450B will be sent to the Area Agency on Aging for final review and determination.

5. The decision on admission, as well as the level of care *(as applicable),* will be entered in Section III and will be sent to the County Division of Family and Children, to the nursing facility and the PAS agency as appropriate.

6. For ICF / MR applicants, Section VI must also be completed and submitted for level of care determinations.

   For PAS ARR/ MR applicants / residents requiring a Level II assessment, Section VI must also be completed and submitted for level of care determinations.

Appeal Rights / How to Request an Appeal

If you are not satisified with this decision, you may request an appeal within 30 days of the date of receipt of this decision. Send a letter with your signature to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, 402 W. Washington St., Rm. W392, Indianapolis, Indiana 46204. (470 IAC 1-4 *et. seq*.) Be sure that the letter contains your address and a telephone number where you can be reached. It is also helpful if you attach a copy of this decision or state the nature of the action you are appealing. If you are unable to write this letter yourself, you may have someone assist you in requesting this appeal.

You will be notified in writing by the Division of Family and Children of the date, time and place for the hearing. Prior to, or at the hearing, you will have the right to examine the entire contents of your case record. You may represent yourself at the hearing or authorize a representative such as an attorney or other spokesperson to do so. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question or refute any testimony or evidence presented.

C.H.O.I.C.E. PROGRAM APPLICANTS / CLIENTS: If you are not satisified with the decision on your C.H.O.I.C.E. case, you should discuss this matter with staff at your Local Area Agency on Aging.

DISCLOSURE STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of public assistance and/or services administered by the State of Indiana. Disclosure of the information requested is mandatory pursuant to the provision of IC 12-15-2 *et. seq.* (Medicaid Programs); IC 12-10-10 *et. seq.* (C.H.O.I.C.E. Program); and IC 12-21 (Division of Mental Health). Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance or services to you. All personal information collected on this form will be treated as confidential pursuant to Regulation 470 IAC 1-3-1.